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Accumulator adjustment programs, copay maximizers, and alternative funding programs

Trends in payer adoption and implications for patient access



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Introduction

Commercial health insurance is the most common type of insurance coverage in the United States, representing roughly two-thirds of insured individuals.¹ It includes state-regulated coverage sold to individuals and groups, including employers, as well as self-funded employer coverage regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA). In this paper, the term “employer-sponsored plans” refers to fully insured and self-funded ERISA plans which, unlike standard commercial offerings, may be customized in response to employer preferences.

Across commercial coverage types, health insurers design benefits and reimbursement strategies to manage healthcare quality and utilization, and to limit spending. For example, for prescription drug benefits, patients and providers generally must adhere to a formulary of covered products and conditions for access, including patient cost-sharing requirements.

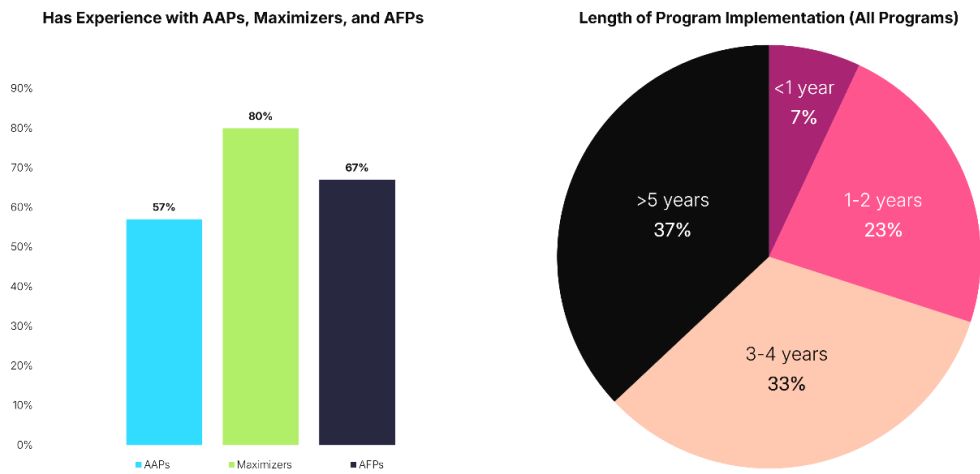
Over the past decade, plans have adopted new strategies to reduce their prescription drug costs. Two of these strategies, known as accumulator adjustment programs (AAPs) and copay maximizer programs (maximizers), apply when a plan enrollee uses some type of third-party assistance to help meet their plan’s cost-sharing requirements. The third approach, alternative funding programs (AFPs), removes specific medicines from insurance coverage entirely and instead directs patients—typically aided by a vendor—to charitable assistance programs originally established to serve uninsured patients. These practices all determine whether and when affected patients can meet deductibles and/or annual coverage limits and may cause coverage uncertainty for patients throughout the year.

Avalere Health surveyed commercial plan decision-makers regarding current and expected adoption of these three strategies. The survey found that all three program types – AAPs, maximizers, and AFPs – are widely and increasingly used by commercial plans (Figure 1); more than 60% of the programs included in the survey were implemented within the last four years.

As policymakers and other stakeholders consider the impact of plans’ cost-avoidance strategies on patients, it is important to keep data limitations in mind. Notably, survey respondents mentioned a lack of data tracking on key measures, including patient medication adherence, outcomes, satisfaction, and costs. Respondents cited cost containment and premium reduction as plans’ primary motivations for program adoption, but these metrics were not verified by additional data analysis.

¹ US Census Bureau. “Health Insurance Coverage in the United States: 2024.” Published Sep. 9, 2025. Accessed Jan. 22, 2026. <https://www.census.gov/library/publications/2025/demo/p60-288.html>.

Figure 1. Respondent Experience with AAPs, Maximizers, and AFPs

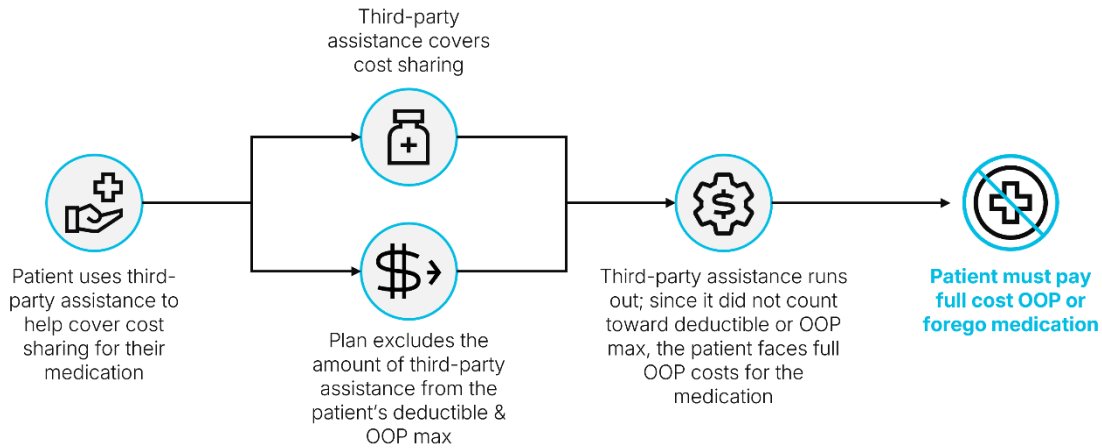


Overview of program types and considerations

AAPs, maximizers, and AFPs operate through distinct mechanisms and can pose different challenges for patients. The first two approaches are designed to modify the impact of third-party assistance within the insurance benefit, while AFPs operate outside of insurance; coverage for certain medicines is withheld and patients are directed to these external assistance programs.

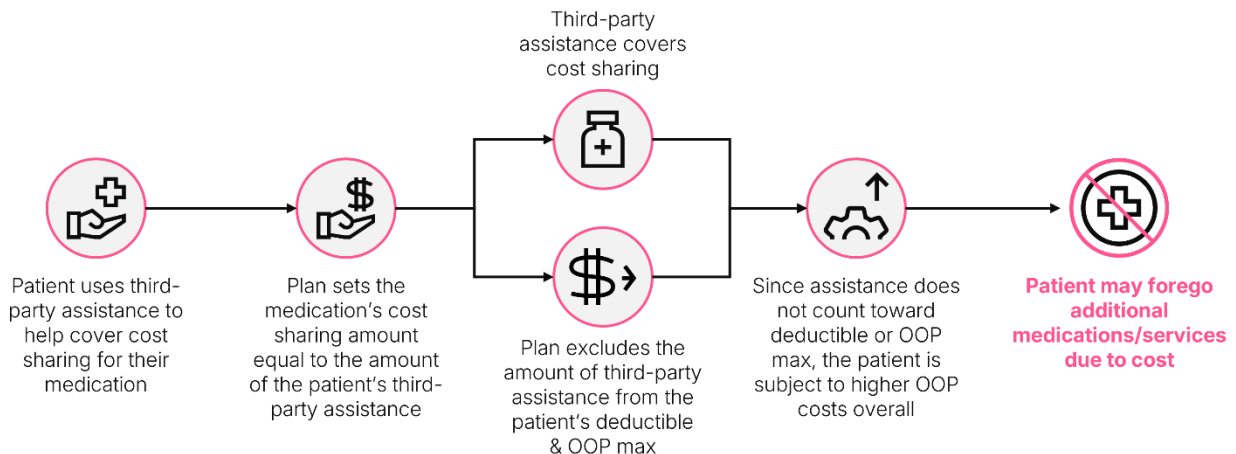
Accumulator adjustment programs prevent manufacturer-provided and other third-party assistance from counting toward a patient's deductible or annual out-of-pocket (OOP) maximum (Figure 2). They may be applied to all prescriptions filled with cost-sharing assistance or only to some (e.g., brands with available generics or products in a certain therapeutic area or above a cost threshold). Because third-party payments are identified by the plan and excluded from patients' accrued spending, patients may be unable to reach deductibles or OOP maximums once an AAP is in place and therefore face more costs throughout the year. In some cases, a patient may be unaware of the AAP until patient assistance resources are exhausted, at which point the patient may face substantial cost exposure (i.e., up to the full amount of the deductible) for future prescriptions. For health plans, slowing a patient's progression through benefit design parameters could be financially beneficial to the plan (but not the patient), since it may avoid triggering an OOP maximum that subjects plans to higher costs. However, if a patient discontinues a medication as a result, other plan costs may arise.

Figure 2. Potential impact of AAPs on patients



Copay maximizers also exclude patient assistance from counting toward deductibles or OOP maximums but may avoid some of the concerns with AAPs for patients (Figure 3). With a maximizer, the plan increases patient cost sharing on a product with a known assistance program to equal the maximum amount of assistance available from the manufacturer. In this way, the patient may avoid a mid-year surprise, as can be seen with AAPs, but they would still need to satisfy benefit design parameters through spending on other items or services. As a result, patients may face higher overall cost exposure across the plan year than if the maximizer were not in place. This could be a net positive for plans; however, as noted above, cost-based nonadherence to other medicines or avoiding needed care could also yield higher plan costs.

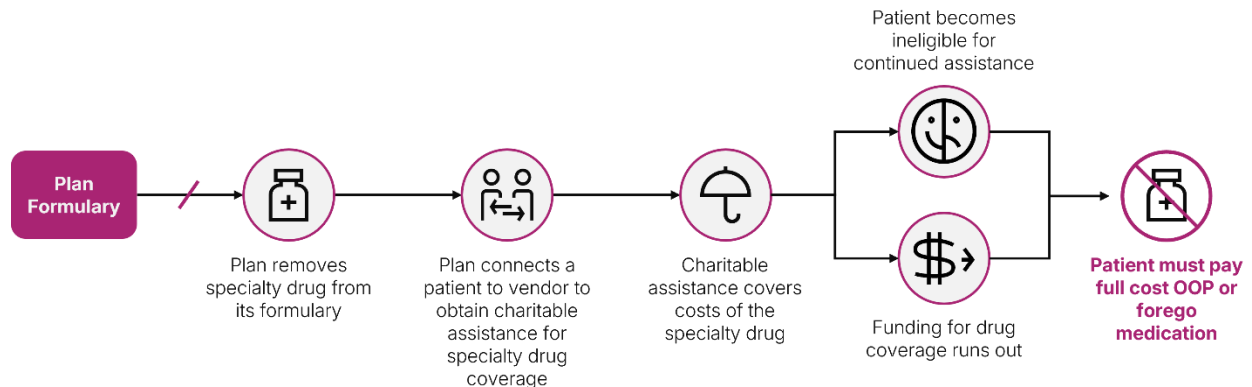
Figure 3. Potential impact of maximizers on patients



Alternative funding programs operate outside of the insurance benefit and rely on employer plan design decisions that exclude certain high-cost specialty medicines from coverage—often by designating these drugs as “non-essential” health benefits that would otherwise be covered as Essential Health Benefits (EHBs). Under these designs (using flexibilities afforded to employer plans

in particular), patients are redirected to third-party vendors that facilitate enrollment into external assistance programs, including charitable foundation or manufacturer assistance (Figure 4).² The vendor may receive a fee based on plan or employer savings achieved by not providing coverage. Because prescriptions subject to AFPs are not covered by insurance, patient payments at the pharmacy counter do not count toward deductibles or OOP limits, raising patient-related concerns similar to those mentioned above. Other patient concerns include care gaps and delays if a patient is ineligible for third-party assistance, based on income or otherwise, and the exhaustion of assistance funds due to growing demand. Plans may pursue AFP strategies to reduce drug spending in the short term, but care disruptions may result in longer-term costs. In addition, for employer plans, there may be concerns with negative reactions from employees due to additional administrative burden (e.g., working with another vendor), or disagreement with relying on charitable assistance intended for uninsured and medically needy patients. There may also be surprise or confusion when the drugs that employees expect to be covered through their insurance benefit are carved out and administered through an AFP, particularly given limited transparency around these arrangements. Public reporting suggests that employers sometimes adopt AFP-like benefit structures without fully understanding the implications for patients, and that plan participants often learn about analogous programs only when facing unexpected denials or higher OOP costs.^{3,4}

Figure 4. Potential impact of AFPs on patients



² American Medical Association. "Alternative Funding Programs." 2025. Accessed Jan. 30, 2026. <https://www.ama-assn.org/system/files/issue-brief-alternative-funding-programs.pdf>.

³ NCODA. "Alternative Funding Programs: Implications for Patient Care." Published Sep. 25, 2025. Accessed Jan. 29, 2026. <https://www.ncoda.org/news/alternative-funding-programs-implications-for-patient-care/>.

⁴ PAN Foundation. "Copay accumulators and programs that harm access to healthcare." Accessed Jan. 29, 2026. <https://www.panfoundation.org/protecting-your-access-to-medications/>.

Payer survey methods

Avalere Health collaborated with a third-party vendor to design and administer a double-blind survey of commercial health plan decision-makers. The goal was to assess the current and anticipated implementation of AAPs, maximizers, and AFPs, and to gain insight into payers' views of program purposes and outcomes. The survey was fielded in 2025 and targeted respondents serving in relevant roles at the Director or Vice President level, or who had held such roles within the prior year.

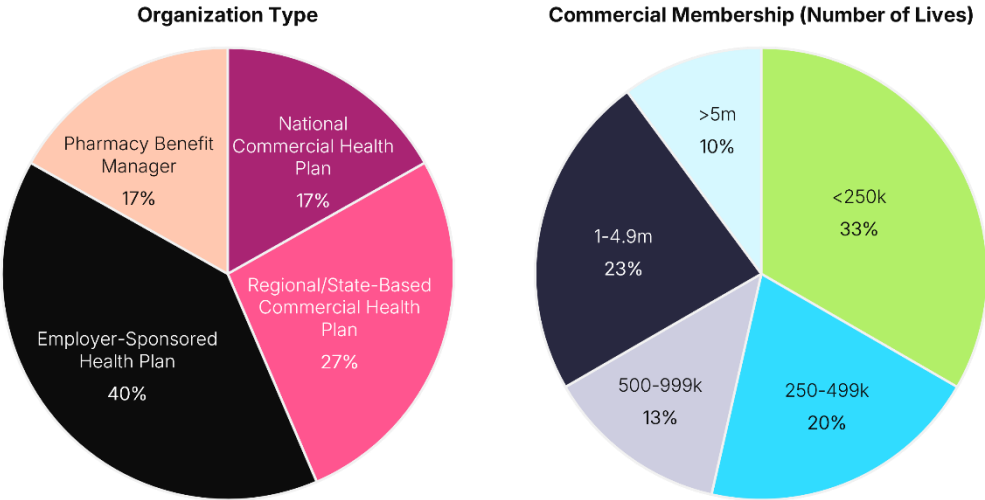
Survey questions focused on program implementation, payer motivations, downstream effects, perceived impacts on patients and providers, and anticipated responses to policy reforms. While the survey asked respondents about current and prior experience with these programs, it was limited in differentiating current and prior experience across respondents.

Payer survey results

Respondent characteristics

A total of 30 respondents completed the survey. Respondents represented a mix of employer-sponsored health plans (40%), regional or state-based commercial health plans (27%), national commercial health plans (17%), and pharmacy benefit managers (PBMs) (17%) (Figure 5). Plan size varied: 33% of respondents represented plans with <250,000 covered lives, 20% represented plans with 250,000–499,999 lives, and 23% represented plans with 1–4.9 million lives.

Figure 5. Survey respondent characteristics



Responses may reflect a combination of direct operational experience and broader organizational perspectives, particularly for plans operating across multiple lines of business (e.g., respondents overseeing both fully insured and self-funded employer products, individual products, and government lines of business). As such, findings were interpreted as reflecting overarching, plan-level views.

Patterns in payer use and adoption

Drivers of implementation

Among the organization representatives surveyed, the majority reported current or prior experience with AAPs (57%), maximizers (80%), and AFPs (67%). Across all three program types, cost containment and premium reduction were the most cited motivations for adoption; however, the survey did not assess whether reported or perceived savings to plans translated into premium reductions for enrollees. Nearly nine in ten (88%) respondents using AAPs identified cost containment as a primary driver, followed by 75% of respondents using maximizers and 60% using AFPs.

For AFPs, employer demand was a significant factor driving adoption. This may be due to direct marketing to employers by vendors promising savings and premium reductions. With health insurance premiums rising (e.g., increasing 26% on average from 2020–2025 for family coverage),⁵ stakeholders report that AFPs emerged as a way to help employers offset these costs.⁶ However, available evidence suggests that demonstrated cost savings are limited and may reflect cost shifting rather than true cost reduction. Analyses indicate that administrative fees and shared savings arrangements may capture a portion of savings for AFP vendors, while patients may experience increased administrative burden, treatment delays, or OOP exposure if alternative funding is unsuccessful. In addition, AFPs rely heavily on charitable patient assistance programs to subsidize drug costs for commercially insured individuals, effectively shifting costs to programs intended for uninsured or medically needy patients and raising concerns about sustainability.⁷

Scope of implementation

AAPs and copay maximizers were most often reported as being implemented broadly across products. Among plans using AAPs, 71% reported implementing them across all commercial products, including specialty and non-specialty benefits, while 63% of plans using copay maximizers reported similarly broad application. This pattern may reflect respondent composition, as employer-sponsored plans, which represent 40% of surveyed organizations, may deploy these

⁵ KFF. "2025 Employer Health Benefits Survey." Published Oct. 22, 2025. Accessed Feb. 4, 2026. <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>.

⁶ Leavitt Partners. "The Present and Future of Alternative Funding Programs for Specialty Drugs." Published Aug. 2024. Accessed Jan. 20, 2026. <https://leavittpartners.com/the-present-and-future-of-alternative-funding-programs-for-specialty-drugs/>.

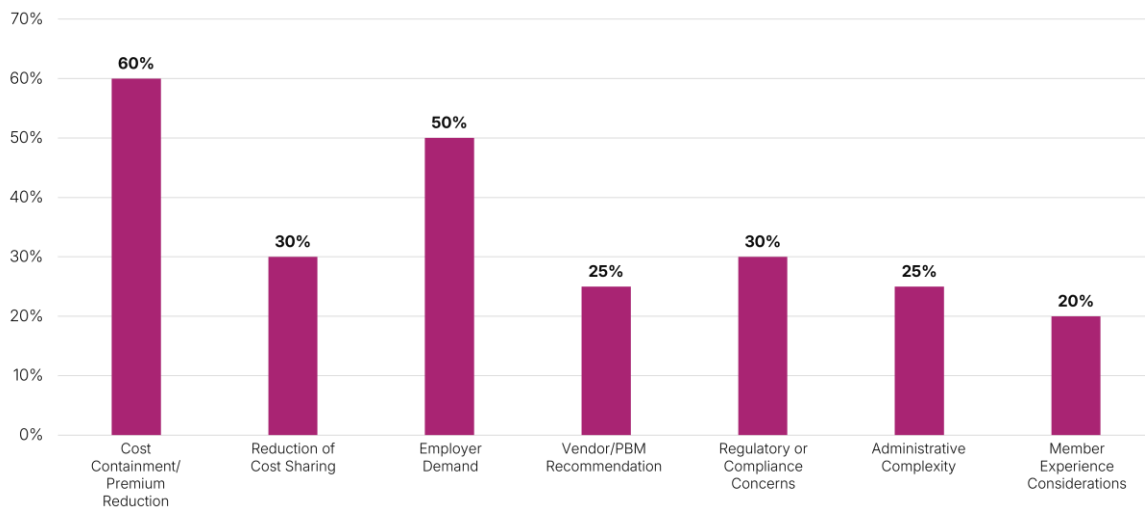
⁷ Ibid.

programs selectively for certain employer groups rather than uniformly across all commercial products.

Notably, just 17% of respondents reported discontinuing the use of AAPs as a result of state-level AAP bans (enacted in 25 states, DC, and Puerto Rico).⁸ This may reflect the limited applicability of these bans to fully insured plans, as well as plan strategies to modify (47% reported modifying approaches) or geographically tailor program design. State laws that prohibit copay adjustment or similar programs generally apply only to state-regulated health plans and not to self-funded employer plans, limiting their impact on the broader commercial insurance landscape. In addition, federal regulatory action to enforce or clarify prohibitions on certain benefit design tools has been limited, leaving oversight gaps.⁹

AFPs were more likely to be implemented selectively; 40% of respondents applied AFPs across all commercial products, with use reportedly driven by cost containment, employer demand, reduction of cost sharing, or regulatory/compliance concerns (Figure 6). For context, a 2023 survey of commercial plans found that 21% of respondents were using or exploring the use of AFPs; however, sample sizes and respondents differ between the two surveys.¹⁰

Figure 6. Primary drivers behind plans' AFP implementation decisions



⁸ Avalere Health. "State Copay Accumulator Bans Now Affect At Least 17% of Commercial Lives." Published Dec. 10, 2025. Accessed Jan. 30, 2026. <https://advisory.avalerehealth.com/insights/state-copay-accumulator-bans-now-affect-at-least-17-of-commercial-lives>.

⁹ KFF. "Copay Adjustment Programs: What Are They and What Do They Mean for Consumers?" Published Oct. 24, 2024. Accessed Jan. 29, 2026. <https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/#ac2ac3a5-95af-47b7-bee7-1f9291e6ac27--federal-and-state-actions>.

¹⁰ Pharmaceutical Strategies Group. "2024 Trends in Specialty Drug Benefits Report." Published Spring 2024. Accessed Jan. 20, 2026. <https://link.psgconsults.com/2024-trends-in-specialty-drug-benefits-report>.

Reported impacts on plans, patients, and manufacturers

Plan operations and contracting

AAPs were most consistently associated with positive financial outcomes for plans by survey respondents; 71% reported plan savings following AAP implementation. However, respondents also described AAPs as administratively challenging, noting that effective implementation required significant time and clear communication. Maximizers were frequently described as complex by survey respondents, primarily due to administrative workload, but integral to plans' broader cost containment strategies.

AFPs were less consistently associated with plan savings and were most often described as having neutral aggregate impacts on administrative workload and provider burden. This may reflect the fact that AFPs are implemented outside of plan operations, typically through another vendor. Respondents highlighted potential complexity and patient confusion in specific circumstances, particularly when coverage changes occur (i.e., if a patient does not qualify for a patient assistance program). It is also worth noting that plans would not receive manufacturer rebates on products covered through an AFP, suggesting a trade-off in terms of plan savings. Perception of declining average rebates among some respondents may account for these results.

Patient affordability, adherence, and experience

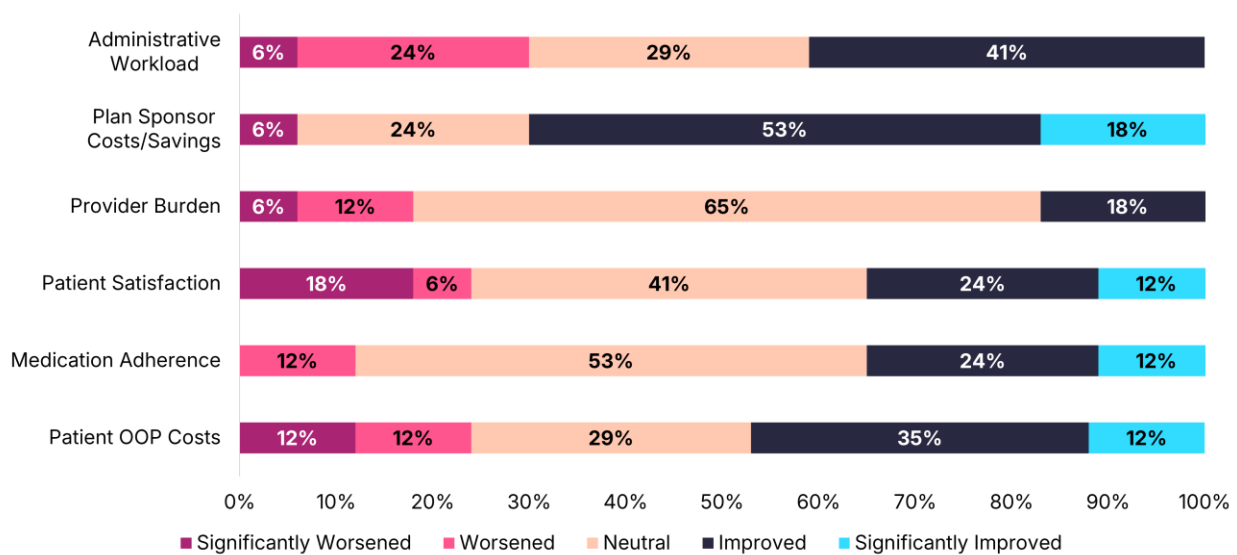
Across all programs, most plans reported non-comprehensive tracking of medication adherence and health outcomes: 59%, 57%, and 55% for plans using AAPs, maximizers, and AFPs, respectively. The lack of comprehensive tracking underscores gaps in evidence regarding patient impacts. Responses from survey participants likely reflect individual perspectives, as opposed to patient-reported metrics.

For AAPs, payer respondents characterized the impact of these programs on patient OOP costs as neutral (29%) or improved (47%). Additionally, plans largely reported neutral effects regarding the impact of AAPs on adherence (53%) and patient satisfaction (41%) (Figure 7). As noted above, however, given the limited tracking of patient costs, adherence and outcomes data, these responses appear to reflect plan-level perceptions or opinions.

In contrast, multiple peer-reviewed studies evaluating these programs note an association with reduced medication adherence, lower persistence, and higher rates of discontinuation or

abandonment, consistent with evidence that abrupt increases in patient OOP costs can disrupt adherence and create financial strain for patients.^{11,12,13}

Figure 7. Payer reported/perceived impact of AAPs



Payers responding to this survey associated maximizers with improved patient satisfaction and adherence relative to other adjustment programs, particularly AAPs. Specifically, 55% of respondents reported improved medication adherence and 63% reported improved patient satisfaction following copay maximizer implementation (Figure 8). Again, given limited patient data tracking reported by respondents, these responses may reflect payer opinions only. Respondents also cautioned that health insurance benefits were not always fully realized, a statement supported by patient advocacy groups emphasizing that these programs can increase patients' OOP burden and contribute to treatment delays, even when plans perceive neutral or improved experience.¹⁴

Plan respondents generally attributed perceived program-related improvements to predictable or reduced monthly cost sharing; however, only 8% of respondents reported comprehensively tracking patient outcomes associated with maximizers. Moreover, these benefits may reflect relative

¹¹ Zuckerman, Autumn D., Megan P. Schneider, and Stacie B. Dusetzina. "Health Insurer Strategies to Reduce Specialty Drug Spending—Copay Adjustment and Alternative Funding Programs." *Health Care Policy and Law* 183, no. 7 (2023): 635-636. Doi:10.1001/jamainternmed.2023.1829.

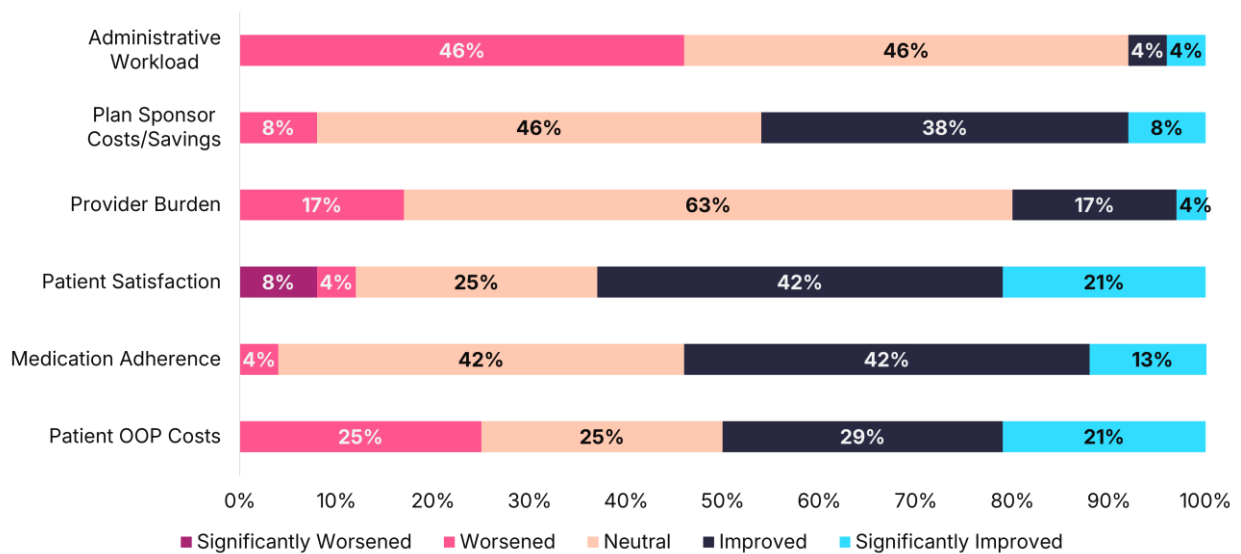
¹² Sherman, Bruce W., Andrew J. Epstein, Brian Meissner, and Manish Mittal. "Impact of a Co-pay Accumulator Adjustment Program on Specialty Drug Adherence." *American Journal of Managed Care* 25, no. 7 (2019): 335-340. <https://www.ajmc.com/view/impact-of-a-copay-accumulator-adjustment-program-on-specialty-drug-adherence>.

¹³ Baser, Onur, Katarzyna Rodchenko, Heidi C. Waters, et al. "The Impact of Copay Accumulators and Maximizers on Treatment Patterns, Adherence, and Costs Among Patients with Major Depressive and Bipolar Disorders Treated with Branded Therapies." *Journal of Market Access and Health Policy* 13, no. 4 (2025): 55. Doi:10.3390/jmahp13040055.

¹⁴ HIV and Hepatitis Policy Institute et al. v. United States Department of Health and Human Services et al., 1:22-cv-02604 (2023).

improvement rather than absolute gains in affordability or access, as 58% of respondents also reported increased patient cost-sharing differentials. This finding may reflect structural limitations in plan data and incentives, as plans may be more inclined and able to monitor utilization, spending, and cost-sharing predictability than patient-level outcomes such as adherence, persistence, or treatment disruption.

Figure 8. Payer reported/perceived impact of maximizers



AFPs were generally described by payers as neutral across patient OOP costs (60%), provider burden (60%), and adherence (45% neutral; 45% improved). As AFPs rely on third-party assistance outside of the health plan, however, plan respondents would have limited visibility into when assistance is delayed, denied, or runs out. The Patient Access Network Foundation indicates that patients may be subject to the full OOP cost of their medication if assistance runs out or is unavailable, or if the patient does not qualify for certain types of assistance.¹⁵ A survey of patient groups, foundations, and/or individual patients could give further insight into the patient journey with AFPs.

Additionally, 70% of respondents acknowledged their perception that patients enrolled in AFPs occasionally become ineligible for patient assistance programs. This finding is consistent with recent changes among charitable foundations, many of which have tightened eligibility criteria to exclude commercially insured or “functionally uninsured” patients to mitigate the impact of AFPs.¹⁶

¹⁵ PAN Foundation. “Copay accumulators and programs that harm access to healthcare.” Accessed Jan. 20, 2026. <https://www.panfoundation.org/protecting-your-access-to-medications/>.

¹⁶ Kang, So-Yeon, Aditi Sen, Ge Bai, and Gerard F. Anderson. “Financial Eligibility Criteria and Medication Coverage for Independent Charity Patient Assistance Programs.” *JAMA Network* 322, no. 5 (2019): 422-429. Doi:10.1001/jama.2019.9943.

Respondents noted that coverage responses varied widely once patients were deemed ineligible for manufacturer patient assistance programs (PAPs). In some cases, plans reported making coverage determinations only after PAP denial, with 30% indicating case-by-case exceptions and another 30% reporting that coverage may ultimately be provided through the plan or employer/vendor following assistance denial. However, 10% of respondents indicated that patients may remain without coverage after PAP ineligibility. Respondents noted the need for strong communication and stakeholder coordination, particularly when coverage changes or assistance eligibility is reassessed, but survey responses did not confirm whether this is happening.

Discussion

Policy efforts to limit or reshape program use

State action and limits under ERISA-governed employer plans

More than half of US states have enacted or proposed legislation to require health plans to count third-party payments toward patient deductibles and OOP maximums.¹⁷ These laws apply to state-regulated commercial plans, including individual and small-group coverage and fully insured employer plans; however, they do not extend to self-insured employer plans governed by ERISA, which account for the majority of privately insured lives (57% in 2024).^{18,19} As a result, while state policymakers have sought to preserve the intended function of copay assistance, the reach of these efforts is constrained by federal preemption under ERISA. Even so, the level of state legislative activity underscores persistent policymaker concerns about the impact of copay adjustment programs on patient affordability and access. These concerns are further elevated by patient advocacy groups.²⁰

Federal regulatory developments affecting ACA-compliant plans

At the federal level, regulatory approaches to copay adjustment strategies have shifted over time. A 2023 federal court ruling vacated prior Centers for Medicare & Medicaid Services (CMS) guidance that had permitted accumulator programs in Affordable Care Act (ACA)-compliant plans where

¹⁷ National Conference of State Legislatures. "Copayment Adjustment Programs." Updated Dec. 11, 2025. Accessed Jan. 16, 2026. <https://www.ncsl.org/health/copayment-adjustment-programs>.

¹⁸ Congressional Research Service. "Federal Preemption: A Legal Primer." Updated May 18, 2023. Accessed Feb. 4, 2026. <https://www.congress.gov/crs-product/R45825>.

¹⁹ KFF. "Share of Private-Sector Enrollees Enrolled in Self-Insured Plans." 2024. Accessed Feb. 4, 2026. <https://www.kff.org/state-health-policy-data/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans/>.

²⁰ Crohn's & Colitis Foundation. "FAQ Court Decision on Copay Accumulators." Mar. 2024. Accessed Jan. 20, 2026. <https://www.crohnscolitisfoundation.org/sites/default/files/2024-03/Copay%20Accumulator%20FAQs%20on%20Recent%20Court%20Case.pdf>.

allowed by state law, but enforcement has been limited while additional rulemaking is anticipated.²¹ More recently, CMS clarified that all covered prescription drugs must be treated as EHBs under ACA plans, meaning that cost-sharing protections apply when a plan includes a drug on its formulary.²² This clarification aims to address certain design workarounds used with copay maximizer strategies. Importantly, this policy applies only to the drugs a plan elects to cover and does not require coverage of specific therapies. Because AFPs carve drugs out of coverage entirely, they are not directly affected by this EHB clarification and may continue to grow.

Prospective federal legislative action

Looking ahead, the bipartisan Help Ensure Lower Patient (HELP) Copays Act represents the most comprehensive effort to address copay adjustment practices.²³ If enacted, the legislation would require all health plans to apply third-party payments toward patient deductibles and OOP maximums unless a generic equivalent is available, effectively standardizing protections across plan types and closing ERISA-related gaps. Despite bipartisan support for the legislation, stakeholders do not view it as likely to be enacted in the current Congress.

Outlook for health plans

Despite growing regulatory scrutiny and patient concerns, most surveyed organizations expect adjustment programs to remain part of their benefit strategies. While 47% of respondents reported modifying implementation approaches in response to state-level AAP bans, only 17% discontinued AAPs in affected states entirely. This pattern suggests that plans may view regulatory compliance as a design constraint rather than a directive to discontinue program use and likely reflects continued use in ERISA plans that are exempt from state laws. Seventy percent of respondents reported being “somewhat concerned” about potential federal action to further restrict these programs.

If additional restrictions are imposed, nearly half of respondents (47%) indicated they would likely increase premiums or patient cost sharing—two trends that have been occurring even with these programs in place.²⁴ Most respondents reported being somewhat likely (53%) or very likely (23%) to continue or expand use of adjustment programs over the next two to three years. Evidence related to patient outcomes (63%) and cost savings (57%) was identified as most likely to influence plan decision-making, although survey results suggest limited tracking of the former.

These findings highlight the types of evidence and tradeoffs that may be most salient to policymakers as they consider the potential effects of further reforms on these programs. These

²¹ HIV and Hepatitis Policy Institute et al. v. United States Department of Health and Human Services et al., 1:22-cv-02604 (2023).

²² US Department of Health and Human Services. “HHS Notice of Benefit and Payment Parameters for 2025.” *Federal Register* 89, no. 73 (Apr. 15, 2024): 26218. <https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf>.

²³ US Congress. “H.R.830 – HELP Copays Act.” <https://www.congress.gov/bill/118th-congress/house-bill/830>.

²⁴ KFF “Health Care Costs and Affordability.” Published Oct. 8, 2025. Accessed Jan. 22, 2025. <https://www.kff.org/health-costs/health-policy-101-health-care-costs-and-affordability/>.

findings also reflect the need for additional data analysis to quantify actual patient impacts (e.g., cost, adherence, and outcomes).

Implications for patient access: Illustrative vignettes

Taken together, the following scenarios illustrate how adjustment programs that appear neutral or beneficial in aggregate survey results may introduce access risks when layered across therapies or disrupted by life events. For patients managing chronic or lifelong conditions, including respiratory diseases and HIV, the interaction of accumulators, maximizers, and AFPs may increase financial unpredictability and administrative burden, with potential consequences for treatment continuity.²⁵ These vignettes highlight the importance of evaluating adjustment programs not only through plan-level cost metrics, but also through patient-centered considerations that reflect real-world complexity and transitions in coverage.

Vignette 1: Accumulator programs and mid-year cost exposure in chronic specialty care

Maria is a 49-year-old woman living with severe asthma and type 2 diabetes who requires a specialty injectable therapy alongside daily maintenance medications. She is commercially insured through her employer and relies on manufacturer copay assistance to afford her specialty treatment.

Under her plan's AAP, manufacturer assistance lowers Maria's point-of-sale cost but does not count toward her deductible or annual OOP maximum. Early in the year, her OOP costs appear manageable. Midyear, however, manufacturer assistance is exhausted and Maria becomes responsible for the full coinsurance amount for her specialty therapy. Confronted with unexpected cost exposure, Maria delays treatment, leading to worsening symptom control and increased use of acute care services like physician visits, urgent care encounters, emergency department visits, and potentially avoidable hospitalizations, each of which can carry substantial additional costs for both Maria and the health system (For example, Duke Health found that in 2018, medication nonadherence in the US was associated with 125,000 deaths and at least 10% of hospitalizations, as well as \$100 billion in direct costs.)²⁶

This scenario reflects survey findings that, while 47% of plan respondents reported neutral or improved patient OOP outcomes following AAP implementation, these programs are designed to delay the accumulation of cost sharing toward deductibles and OOP maximums. Apparent affordability early in the plan year may therefore obscure downstream access risks once assistance is depleted.

²⁵ HIV and Hepatitis Policy Institute et al. v. United States Department of Health and Human Services et al., 1:22-cv-02604 (2023).

²⁶ Pittman, T. "Medication Nonadherence Increases Health Costs, Hospital Readmissions." *Duke Health*. Published Nov. 20, 2018. Accessed Jan. 30, 2026. <https://physicians.dukehealth.org/articles/medication-nonadherence-increases-health-costs-hospital-readmissions>.

Vignette 2: Overlapping adjustment programs and coverage transitions in complex care

James is a 34-year-old man living with HIV who requires continuous antiretroviral therapy and treatment for comorbid conditions. His employer-sponsored plan routes one high-cost therapy that is not covered by the plan through an AFP, requiring enrollment in a third-party assistance pathway, while another medication, which is covered by the plan, is subject to a copay maximizer that spreads manufacturer assistance evenly throughout the year.

The copay maximizer provides predictable, relatively affordable monthly costs, consistent with survey findings that 63% of respondents associated maximizers with improved patient satisfaction and 55% with improved adherence. However, neither program allows manufacturer assistance to count toward the deductible or OOP maximum. As a result, James makes little progress toward meeting his deductible despite ongoing treatment costs, leaving him exposed to OOP spending for other covered medical services that would otherwise have been partially or fully covered later in the plan year.

Mid-year, James changes jobs and enrolls in a new health plan. While plan transitions commonly involve a deductible reset, the alternative funding arrangement and copay maximizer introduce additional disruption: the AFP must be reestablished with a new third-party vendor, documentation resubmitted, and eligibility reassessed, while none of the prior manufacturer assistance payments count toward the new plan's deductible or OOP maximum. Because the prior plan's maximizer was designed to draw down as much manufacturer assistance as possible, James may find himself with no remaining assistance after transferring into the new plan. During this transition, James faces delays and upfront costs tied to re-enrollment and assistance approval, increasing the risk of treatment interruption.

This scenario aligns with survey findings that AFPs are often described as administratively complex and a source of patient confusion, with 70% of respondents reporting that patients enrolled in AFPs occasionally become ineligible for patient assistance programs. Even routine coverage changes can therefore create meaningful access disruptions for patients dependent on continuous therapy.

Conclusion

Survey findings suggest that AAPs, maximizers, and AFPs have become embedded tools for managing drug spending by plans and PBMs, driven primarily by cost containment objectives. AFPs, in particular, have become more prevalent, attributed in part to employer demand. While survey respondents report confidence in realized savings, they also note administrative complexity and a lack of comprehensive data tracking on patient affordability, adherence, and outcomes across all programs. Further study is warranted to identify the degree of disconnect between plan responses and patients' lived experiences with these programs. Regarding AFPs, plans appear to lack insight into vendor data that would enable continuous coverage and patient transitions when charitable

assistance is exhausted or unavailable. Further review is needed to assess broader impacts of AFP growth on enrolled patients and the healthcare safety net.